STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
SOUTHERN REGION

Human Resources
1010 W. Columbia
Farmington, MO 63640

EMPLOYMENT APPLICATION

Please check one or both facilities

☐ *Southeast Missouri Mental Health Center*

☐ *Missouri Sexual Offender Treatment Center*

NAME (LAST)	(FIRST)	(MIDDLE)	SOCIAL SECURITY NUMBER		
ADDRESS	CITY		STATE	ZIP CODE	COUNTY
TELEPHONE NUMBER	ALTERNATE / CELL NUMBER	HAVE YOU WORKED UNDER ANY OTHER NAME? ☐ YES ☐ NO IF YES, WHAT NAME(S)?	MAIDEN NAME		

FOR WHAT POSITION(S) ARE YOU APPLYING? _____

HOW DID YOU LEARN ABOUT THIS POSITION? ☐ Newspaper ☐ Division of Family Services ☐ Family/Friend:_____
☐ Job Service ☐ Just walked in ☐ Other: _____

FOR WHAT TYPE OF EMPLOYMENT ARE YOU APPLYING? ☐ FULL TIME ☐ PART TIME ☐ TEMPORARY ☐ ANY

WHAT IS THE MINIMUM SALARY YOU WILL ACCEPT? _____

STATE LAW PROHIBITS THE HIRING OF RELATIVES IN CERTAIN SITUATIONS. DO YOU HAVE ANY RELATIVES (SPOUSE, CHILD, PARENT, SIBLING, GRANDPARENT, OR GRANDCHILD) WORKING FOR THE DEPARTMENT OF MENTAL HEALTH? ☐ YES ☐ NO
IF YES, STATE DETAILS _____

HAVE YOU EVER BEEN EMPLOYED BY SOUTHEAST MO MENTAL HEALTH CENTER, MO SEXUAL OFFENDER TREATMENT CENTER OR ANY OTHER STATE FACILITY? ☐ YES ☐ NO IF YES, PLEASE STATE FACILITY NAME, JOB TITLE & DATES OF EMPLOYMENT

_____

HAVE YOU EVER BEEN CONVICTED OF, PLED GUILTY OR NOLO CONTENDERE TO, ANY CRIME OTHER THAN A MINOR TRAFFIC VIOLATION, INCLUDING ANY SUSPENDED IMPOSITION OR EXECUTION OF SENTENCE; OR HAVE YOU SERVED ANY PERIODS OF PAROLE OR PROBATION? ☐ YES ☐ NO IF YES, STATE DETAILS _____

HAVE YOU EVER BEEN FOUND TO HAVE ABUSED OR NEGLECTED ELDERLY OR HANDICAPPED PATIENTS OR RESIDENTS, OR HAVE YOU BEEN PLACED ON THE EMPLOYEE DISQUALIFICATION LIST OF THE DIVISION OF AGING? ☐ YES ☐ NO

TO YOUR KNOWLEDGE, DO YOU HAVE ANY RELATIVES OR FRIENDS CURRENTLY OR POTENTIALLY RECEIVING SERVICES AT THE MISSOURI SEXUAL OFFENDER TREATMENT CENTER, THE CORRECTIONAL TREATMENT CENTER AND/OR FORENSIC PROGRAM AT SOUTHEAST MISSOURI MENTAL HEALTH CENTER? ☐ YES ☐ NO IF YES, THIS WILL BE DISCUSSED CONFIDENTIALLY WITH THE INTERVIEWER.

RECORD OF EDUCATION

HAVE YOU GRADUATED FROM HIGH SCHOOL OR OBTAINED A GED? ☐ **YES** ☐ **NO**
ARE YOU CURRENTLY ATTENDING SCHOOL/COLLEGE? ☐ **YES** ☐ **NO**

LIST COLLEGE, UNIVERSITY, VOCATIONAL SCHOOL, OTHERS, BELOW

NAME AND LOCATION	DATES OF ATTENDANCE	COURSE OF STUDY	SEMESTER HOURS OR CLOCK HOURS COMPLETED	LIST DIPLOMA OR DEGREE ATTAINED
NAME				
LOCATION				
NAME				
LOCATION				

CONTINUED ON BACK

RECORD OF EMPLOYMENT/MILITARY SERVICE

(Begin with current or most recent employer)
(Attach additional sheets if necessary. Résumé may be used if all information is available.)

NAME AND ADDRESS OF EMPLOYER	FROM		TO		HOURS PER WEEK	POSITION HELD AND DUTIES	
	MONTH	YEAR	MONTH	YEAR			
							NAME OF SUPERVISOR
							TELEPHONE
							REASON FOR LEAVING
							NAME OF SUPERVISOR
							TELEPHONE
							REASON FOR LEAVING
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							NAME OF SUPERVISOR
							TELEPHONE
							REASON FOR LEAVING

MAY WE CONTACT YOUR FORMER AND PRESENT EMPLOYER(S)? ☐ YES ☐ NO IF YES, YOUR SIGNATURE BELOW AUTHORIZES ANY FORMER OR CURRENT EMPLOYER TO FURNISH THE DEPARTMENT OF MENTAL HEALTH WITH ANY OR ALL INFORMATION CONCERNING YOUR PREVIOUS EMPLOYMENT AND RELEASES ANY FORMER OR CURRENT EMPLOYER FROM ALL LIABILITY FOR AND DAMAGES IN FURNISHING SUCH INFORMATION.

If you are currently certified, registered, or licensed to practice your profession or occupation, give name of association or licensing authority and certification, registration, or license number.

ASSOCIATION OR LICENSING AUTHORITY	CERTIFICATION, REGISTRATION, OR LICENSE NUMBER
EXPIRATION DATE OF LICENSE/CERTIFICATION	CERTIFIED, REGISTERED, OR LICENSED IN THE STATE OF MISSOURI ☐ YES ☐ NO

HAVE YOU EVER HAD A LICENSE REVOKED OR VOLUNTARILY SURRENDERED A LICENSE?
☐ YES ☐ NO IF YES, STATE DETAILS

SHOULD I BE EMPLOYED BY THIS FACILITY, I UNDERSTAND THAT I WILL BE REQUIRED TO FULFILL ALL ESSENTIAL FUNCTIONS OF THE JOB I AM HIRED TO PERFORM, WITH OR WITHOUT ACCOMMODATION. INABILITY TO DO SO MAY RENDER ME NO LONGER QUALIFIED FOR THE POSITION, AND MAY BE CONSIDERED CAUSE FOR DISMISSAL.

A DRUG SCREEN WILL BE PERFORMED PRIOR TO EMPLOYMENT. EMPLOYMENT WILL BE CONTINGENT UPON NEGATIVE RESULTS.

I UNDERSTAND THAT SOUTHEAST MISSOURI MENTAL HEALTH CENTER / MISSOURI SEXUAL OFFENDER TREATMENT CENTER PROMOTES A DRUG FREE WORK PLACE & AGREE TO TESTING AS THE HOSPITAL DEEMS NECESSARY.

I UNDERSTAND THAT SOUTHEAST MISSOURI MENTAL HEALTH CENTER/MISSOURI SEXUAL OFFENDER TREATMENT CENTER ARE TOBACCO FREE ENVIRONMENTS WHICH PROHIBITS THE USE/POSSESSION OF ALL TOBACCO PRODUCTS ON GROUNDS, BUILDINGS AND PARKING LOTS. I AGREE TO COMPLY WITH SOUTHERN REGION POLICY, R-LD.A.50, TOBACCO-FREE CAMPUS.

I certify that the information contained in this application is true to the best of my knowledge and that any falsification or misrepresentation may result in my dismissal at any time thereafter should I be employed by the state of Missouri.

SIGNATURE	DATE